Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Medicaid Purchasing Administration

Physician-Related Services

Billing Instructions

[Chapter 388-531 WAC]

About This Publication

This publication supersedes all previous Department *Physician-Related Services Billing Instructions* published by the Medicaid Purchasing Administration, Washington State Department of Social and Health Services.

> **Note:** The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **07/01/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected
# Memo 10-45	Fee Schedule and Policy Updates	June 29, 2010	A.3, A.6, B.1, C.1, C.13, C.17, C.26, Section D, E.5, E.32, F.2-F.4, I.6-I.11, K.9, and K.12-K.13

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How Can I Get Department/MPA Provider Documents?

To download and print Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

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Important Contacts

Note: This section contains important contact information relevant to Physician-Related Services. For more contact information, see the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
Contacting Provider Enrollment	
Contacting the Provider Inquiry Hotline	
Pharmacy authorization	
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, the following documentation is "required:" • A completed, TYPED ProviderOne request form, DSHS 13-835. This request form MUST be the initial page when you submit your request. • A completed Basic Information Form, DSHS 13-756, if there is not a form specific to the service you are requesting, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Forms available to submit authorization requests	• Oral Enteral Nutrition Worksheet Prior Authorization Request, DSHS 13-743 • Fax/Written Request Basic Information Form, DSHS 13-756 • Pet Scan Information Form, DSHS 13-757 • Bariatric Surgery Request Form, DSHS 13-785 • Physical, Occupational, and Speech Therapy Limitation Extension Request, DSHS 13-786 • Out of State Medical Services Request Form, DSHS 13-787 • TYSABRI (Natalizumab) J2323 Request, DSHS 13-832 • Application for Chest Wall Oscillator, DSHS 13-841 • Insomnia Referral Worksheet, DSHS 13-850 • Xolair (Omalizumab), DSHS 13-852 • CIMZIA (Certolizumab pegol Inj.) J0718, DSHS 13-885

Other Important Numbers

Acute PM&R Authorization FAX 1-360-725-1966

Client Assistance/Brokered Transportation Hotline **(Clients Only)** 1-800-562-3022

Chemically Using Pregnant (CUP) Women Program Information 1-360-725-1666

Disability Insurance 1-800-562-6074

Durable Medical Equipment (DME)/Prosthetics Authorization.....1-800-292-8064

Fraud Hotline 1-800-562-6906

MPA Managed Care (Healthy Options) Enrollment 1-800-562-3022

Telecommunications Device for the Deaf (TDD) 1-800-848-5429

Third-Party Resource Hotline.....1-800-562-6136

TAKE CHARGE 1-360-725-1652

Provider Field Representatives

To request on-site billing training, call 1-800-562-3022 or email the Department at: ProvEducSupport@dshs.wa.gov.

Department/MPA Billing Instructions

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov for a more complete list of definitions.

Acquisition cost (AC) – The cost of an item excluding shipping, handling, and any applicable taxes.

Acute care – Care provided for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status.

Add-on procedure(s) – Secondary procedure(s) performed in addition to another procedure.

Admitting diagnosis – The medical condition responsible for a hospital admission, as defined by ICD-9-CM diagnostic code. [WAC 388-531-0050]

Assignment – A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Authorization number – A nine-digit number assigned by MPA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Base anesthesia units (BAU) – A number of anesthesia units assigned to an anesthesia procedure that includes the usual preoperative, intra-operative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Bundled services – Services integral to the major procedures that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

By report (BR) – A method of reimbursement in which MPA determines the amount it will pay for a service that is not included in MPA's published fee schedules. MPA may request the provider to submit a "report" describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

Code of federal regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community services office (CSO) – An office of the department that administers social and health services at the community level.

Covered service – A service that is within the scope of the eligible client's medical care program, subject to the limitations in Chapter 388-531 WAC and other published WAC.

Current procedural terminology (CPT™) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association.

EPSDT provider – (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as an EPSDT provider; ***or*** (2) a dentist, dental hygienist, audiologist, or optometrist who is an enrolled Medical Assistance provider and performs all or one component of the EPSDT screening.

HCPCS- See **Healthcare Common Procedure Coding System**.

Healthcare Common Procedure Coding System (HCPCS) - Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Informed consent – Where an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and
(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and
(3) Given the client a copy of the consent form; and
(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and
(5) Given the client oral information about all of the following:
    (a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and
    (b) Alternatives to the procedure including potential risks, benefits, and consequences; and
    (c) The procedure itself, including potential risks, benefits, and consequences.

Inpatient hospital admission – An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

Limitation extension – A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which MPA routinely reimburses. Limitation extensions require prior authorization.

Maximum allowable fee – The maximum dollar amount that MPA reimburses a provider for specific services, supplies, and equipment.

Medical consultant – Physicians employed by MPA who are authorities on the medical aspects of the Medical Assistance program. As part of their responsibilities, MPA medical consultants:

- Serve as advisors in communicating to the medical community the scope, limit, and purpose of the program.
- Assist in the development of MPA medical policy, procedures, guidelines, and protocols.
- Evaluate the appropriateness and medical necessity of proposed or requested medical treatments in accordance with federal and state law, applicable regulations, MPA policy, and community standards of medical care.
- Serve as advisors to MPA staff, helping them to relate medical practice realities to activities such as claims processing, legislative requests, cost containment, and utilization management.
- Serve as liaisons between MPA and various professional provider groups, health care systems (such as HMOs), and other State agencies.
- Serve as expert medical and program policy witnesses for MPA at fair hearings.

Medical Identification card(s) – See *Services Card*.

Medically necessary – See WAC 388-500-0005.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Newborn or neonate or neonatal - A person younger than 29 days old.

Noncovered service or charge – A service or charge not reimbursed by the department.

Patient identification code (PIC) – See *ProviderOne Client ID*.

Pound indicator (#) – A symbol (#) indicating a procedure code listed in MPA's fee schedules that is not covered.

Professional component – The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Relative value unit (RVU) – A unit that is based on the resources required to perform an individual service. RBRVS RVUs are comprised of three components – physician work, practice expense, and malpractice expense.

Remittance and status report (RA) – A report produced by MPA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Resource based relative value scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

RBRVS maximum allowable amount – The Medicare Fee Schedule relative value unit, multiplied by the statewide geographic practice cost index, times the applicable conversion factor.

Revised code of Washington (RCW) – Washington State laws.

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Technical component – The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

Transaction Control Number (TCN) - A unique field value that identifies a claim transaction assigned by ProviderOne.

Usual and customary fee – The rate that may be billed to the Department for certain services, supplies, or equipment. This rate may not exceed:

1) The usual and customary charge billed to the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Unless otherwise noted, billing should reflect the usual and customary fee and not the Department's maximum allowable fee. Reimbursement is either the usual and customary fee or the Department's maximum allowable fee, whichever is less.